

13962

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13964

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGELY				c. LENGTH OF STAY IN 1b life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGELY				d. STREET ADDRESS 051			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH Roy CHERRY				4. DATE OF DEATH OCT 4 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 23, 1910	
9. AGE (In years plus birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH CHERRY				14. MOTHER'S MAIDEN NAME JANE DOUGLAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. J. Roy Cherry Ridgely Address hid.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular fibrillation DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c) with mitral regurgitation & stenosis							INTERVAL BETWEEN ONSET AND DEATH many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Rectum (Wiles record)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 66 , to 9/16 , 19 66 that (I) (we) last saw the deceased alive on 9/16 , 19 66 , and that death occurred at 11 M, from causes and on the date stated above.							
22a. SIGNATURE Kurt Lederer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Kurt Lederer, M.D.	
22d. ADDRESS Queen Anne, Maryland				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVE (Specify)		23b. DATE THEREOF Oct 7, 1966		23c. NAME OF CEMETERY OR CREMATORY GREENSBORO		23d. LOCATION (City or Town) (County) (State) GREENSBORO MD	
24. FUNERAL DIRECTOR J. B. MOORE ADDRESS BENTON				25a. REC'D BY REGISTRAR DATE OCT 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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[Faint, mostly illegible text and markings covering the main body of the document, possibly bleed-through from the reverse side.]

[Vertical text on the right margin, possibly a file number or classification code.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13962

CERTIFICATE OF DEATH

13965

1. PLACE OF DEATH a. COUNTY <div>Caroline</div> <div>MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <div>Maryland</div> <div>Caroline</div>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div>Rural Henderson</div>		c. LENGTH OF STAY IN 1b <div>20 Yrs.</div>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div>None</div>		e. STREET ADDRESS <div>None</div>	
3. NAME OF DECEASED (Type or print) <div>Edward Lee Dove</div>		4. DATE OF DEATH <div>Oct 28 19 66</div>	
5. SEX <div>Male</div>		6. COLOR OR RACE <div>White</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>3-1-1889</div>	
9. AGE (In years last birthday) <div>77 yrs.</div>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>Farmer</div>		12. CITIZEN OF WHAT COUNTRY? <div>USA</div>	
13. FATHER'S NAME <div>Joseph Dove</div>		14. MOTHER'S MAIDEN NAME <div>Mollie Powers</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div>No</div>		16. SOCIAL SECURITY NO. <div>None</div>	
17. INFORMANT <div>William Dove Henderson, Md.</div>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>Coronary Thrombosis</div> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <div>Arteriosclerotic C.V.Dis.with Hypertension</div> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <div>Oct. 28</div> , 1966, to <div>Oct. 28</div> , 1966, that (I) (we) last saw the deceased alive on <div>Oct. 28</div> , 1966, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <div>Charles H. Stonifer</div>		22b. DATE SIGNED <div>Oct. 29, 1966</div>	
22c. PHYSICIAN'S NAME (Type) <div>Charles H. Stonifer, M.D.</div>		22d. ADDRESS <div>Greensboro, Md. 21630</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		23b. DATE THEREOF <div>Oct. 31, 66</div>	
23c. NAME OF CEMETERY OR CREMATORY <div>Greensboro</div>		23d. LOCATION (City, town or county) (State) <div>Greensboro, Md.</div>	
24. FUNERAL DIRECTOR <div>J. E. Boulais, Greensboro, Md.</div>		25a. REC'D BY REGISTRAR DATE <div>NOV 2 1966</div>	
25b. REGISTRAR'S SIGNATURE <div>Charles Judge</div>			

1988

1988

Handwritten notes and signatures, including names like "John Doe" and "Jane Smith", and dates like "1988-01-01".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13954 CERTIFICATE OF DEATH 13966											
1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalsburg c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. Nr. American Corner						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS R.F.D. Nr. American Cor. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Stella First Martha Middle Fishell Last						4. DATE OF DEATH October Month 3 Day 19 Year 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1891		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Mln. IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Caroline County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles W. Smith						14. MOTHER'S MAIDEN NAME Tamsey J. Sullivan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mrs. Cora Donovan, Denton, Maryland R.F.D. Address R.F.D.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation & Failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 1 yr 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchitis and acute upper respiratory infection										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/1/66 , 19 66 , to 10/3/66 , 19 66 , that (I) (we) last saw the deceased alive on 10/3/66 , 19 66 , and that death occurred at 4:50 PM from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer						22d. ADDRESS Preston Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF October 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery				23d. LOCATION (City, town or county) (State) Federalsburg, Maryland			
24. FUNERAL DIRECTOR J. J. Frampton						ADDRESS and Son, Federalsburg, Md.		25a. REC'D BY REGISTRAR OCT 7 1966		25b. REGISTRAR'S SIGNATURE [Signature]	

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208 J. J. J. van der Helm et al.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13965

13967

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Federalsburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South University Avenue				d. STREET ADDRESS 307 South University Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last George Noble Handy				4. DATE OF DEATH Month Day Year October 19 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1904		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Employee at			10b. KIND OF BUSINESS OR INDUSTRY Caroline Foods		11. BIRTHPLACE (State or foreign country) Caroline County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert S. Handy				14. MOTHER'S MAIDEN NAME Lillian Noble			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-16-3383		17. INFORMANT Address Florence E. Handy, Federalsburg, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hit by an Automobile Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Hit by an Automobile DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractures of Both Tibulas & P. thigh over 3rd of Leg							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While working hit by an automobile				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:45 pm 10/19/1966			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road nearby South University Avenue		20f. (City or town) (County) (State) Federalsburg Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Harold B. Plummer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED Oct. 19, 1966	
EXAMINER'S NAME (Type) Harold B. Plummer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Preston, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 22, 1966		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Near Federalsburg, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR OCT 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1988

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg c. LENGTH OF STAY IN 1b 7 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elderkin Nursing Home						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg d. STREET ADDRESS R.F.D. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Walter Marion Love				4. DATE OF DEATH Month October Day 3 Year 1966							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1871		9. AGE (In years last birthday) 95 yrs. IF UNDER 1 YEAR: Months 3 Days 19 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer and Sawmill operator				10b. KIND OF BUSINESS OR INDUSTRY operator		11. BIRTHPLACE (County & State, or foreign country) Caroline County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. Love						14. MOTHER'S MAIDEN NAME Annie E. Payne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lenora Howard, Harmony, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 3rd, 1966 to Oct 4th, 1966 ; that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 6 A M, from the causes and on the date stated above.											
22a. SIGNATURE Frank M. Anderson						22b. DATE SIGNED 10-4-66		22c. PHYSICIAN'S NAME (Type or print) Frank M. Anderson M.D.			
22d. ADDRESS Federalsburg, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Union Grove Cemetery		23d. LOCATION (City, town or county) (State) Near Federalsburg, Maryland					
24. FUNERAL DIRECTOR J. J. Frampton and Son,						25a. REC'D BY REGISTRAR OCT 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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August 2, 1971

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Noted for and Howell

Caroline County

A.S.A.

William T. Love

John E. Love

Mr. James Howard, State of Maryland

and

Mr.

10-1-50

Frank L. Anderson, D.D.

Federal, Maryland

Copy

Oct. 2, 1950

United States

Post Federal, Maryland

Frank and Son, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13967					13970				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Caroline			b. STATE		Maryland		
		MARYLAND			b. COUNTY		Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Denton			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Denton		
c. LENGTH OF STAY IN 1b		26 Yrs.					05-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
None					None				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
Naomi		Frances		Shoemaker		Oct.		15 19 66	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-3-1895		71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				None		Virginia		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
James A. Cooper					Lucy Moliar				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		
No					220-34-9960		E.R. Shoemaker Denton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breasts with 170X DUE TO regional metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1965 to Oct. 15, 1966, that (I) (we) last saw the deceased alive on Oct. 15, 1966, and that death occurred at M., from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
Charles H. Stonesifer							Oct. 17 '66		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Charles H. Stonesifer, M.D.					Greensboro, Md. 21639				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			Oct. 18-66		Denton		Denton, Maryland		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		
J. E. Boulais					Greensboro, Md.		25b. REGISTRAR'S SIGNATURE		
							DATE OCT 21 1966 Charles Judge		

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J. C. Phillips, Secretary, M. C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN lb 32 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) River Road		e. STREET ADDRESS 201 West Central Avenue	
3. NAME OF DECEASED (Type or print) First Marshall Middle Woodrow Last Stoffle		4. DATE OF DEATH Month October Day 15 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1913
9. AGE (In years lost birthday) yrs. 53		10. IF UNDER 1 YEAR Months 3 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager, Caroline Farms Textron Co.		10b. KIND OF BUSINESS OR INDUSTRY Manchester, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward E. Stoffle		14. MOTHER'S MAIDEN NAME Bessie Yingling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-03-9819	
17. INFORMANT Lois M. Stoffle, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 975X DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Depression (c) Depression		INTERVAL BETWEEN ONSET AND DEATH minutes minutes 3-4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found floating in a gravel pit pond	
20c. TIME OF INJURY Month, Day, Year 10/15/66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) gravel pit		20f. (City or town) Caroline (County) Federalsburg (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Harold B. Plummer M.D.		22. DATE SIGNED 10/19/66	
EXAMINER'S NAME (Type) Harold B. Plummer		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland
24. J. M. Hampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR OCT 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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